COVID-19 Vaccine Attestation Form

MassHealth Independent Nurse (IN) Program

This form must be completed by each MassHealth enrolled Independent Nurse, stored in the IN's personal records, and provided to the CCM member and/or their representative to confirm the IN's vaccine status and help the CCM member make decisions about their safety and personal care. **Any IN who refuses to complete this form and/or comply with regulations promulgated, or orders issued, by the Department of Public Health pertaining to COVID-19 vaccination requirements may be subject to discipline, up to and including termination, as determined by the MassHealth agency.**

By signing below, I acknowledge the following:

- I understand that Independent Nurses (INs) working in the MassHealth IN Program are required to complete the full required regimen of COVID-19 vaccine doses by October 31, 2021, per the Massachusetts Department of Public Health regulation 105 CMR 159.000, *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization; **The CCM member and/or their representative can choose to not have me provide CSN services based on this requirement**.
- I can produce proof of my vaccination status or proof supporting my need for a valid exemption; and
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine, I may be at greater risk of contracting COVID-19 and/or spreading it to others.

IN Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full required regimen of COVID-19 vaccine doses. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine.

☐ I have received a COVID-19 vaccine exemption based on one of the following (please check one):

- ☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination; or
- ☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief and I have documentation demonstrating my sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption.

IN Name	IN Signature	Date Signed

The IN must complete this form for each CCM member they support and acquire the CCM member or their representative's signature below to show proof the IN discussed their vaccination status with the CCM member.

CCM Member Name	Member, Surrogate, or Legal Guardian Signature	Date Signed